
RELATIONS WITH STATE HEALTH AND VOCATIONAL
REHABILITATION AGENCIES AND TITLE V GRANTEEES

The Department has an agreement with the Georgia Department of Human Resources to establish cooperative administration and supervision for certain services. Mutual objectives for the arrangement are to produce a statewide system for informing and referral and to enhance the administrative capability to provide maximum utilization of services.

DHR agrees to provide the various support services described in this contract, and DMA agrees to pay DHR the appropriate federal share of the cost of these services on a quarterly basis, with the exception of the Community Care Services program for which DHR agrees to pay DMA the appropriate non-federal share of the cost of the Community Care Services program on a quarterly basis. DHR agrees to bear the non-Federal share of such costs from state or other funds eligible for use in matching such non-Federal share for all other services. DMA and DHR mutually agree that the level and extent of services provided in this contract are contingent upon the availability of both State and Federal funds. In the event either party determines that a service or activity provided for in this contract cannot be performed, a formal written notice will be provided to the Commissioner of the other party no less than thirty (30) days prior to deletion of the service or activity.

Pursuant to the requirements of 42 CFR 431.615, DHR and DMA have established a coordinating committee consisting of the Commissioner or his designee from DMA, the Commissioner or his designee from DHR, and a representative of each appropriate program division of DHR and DM. Said committee shall meet no less than once per quarter to review and evaluate the services provided for in this contract, to explore other avenues of interaction between the parties, and to otherwise meet the requirement of 42 CFR 431.615. The committee, at its discretion, may set up subcommittees to research and/or develop recommendations for solutions to pertinent issues.

Non-Emergency Transportation (NET)

Medicaid Related NET

The provision of Medicaid related NET services (with the exception of EPSDT related NET and NET services provided by direct provider) is the responsibility of the appropriate county Department of Family and Children Services. The local office will arrange and coordinate or provide non-emergency transportation services to DMA eligible clients in accordance with DMA's Policies and Procedures Manual for Non-Emergency Transportation.

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EPSDT Related NET

During Fiscal Year 1986, the responsibility for arranging and coordinating or providing non-emergency transportation services for EPSDT Services will be transferred on a phased-in basis from DFCS to DPH with local health department case managers assuming full responsibility. This will include the locating and negotiation of NET services with the providers of this services to establish contractual arrangements for this purpose. DHR will encourage local health departments to negotiate with local DFCS for assistance in developing or sharing lists of these providers, or the actual provision of the NET services in counties where appropriate and feasible. DMA, Division of Program Management, agrees to provide recipients with notice of availability of non-emergency transportation services. Program Management agrees to provide to DHR NET Manuals, manual revisions, and copies of the Medicaid Provider list.

DHR and DMA Program Management agree to work jointly in the development of policies and procedures for non-emergency transportation services.

Family Planning Services

DFCS agrees that the county offices will inform and explain the availability of family planning services and provide literature to recipients in need of such services.

DHR, Division of Public Health (DPH), agrees to administer a statewide program of family planning clinic services which shall include the provision of pregnancy testing and family planning services to eligible recipients, development of contractual relations with non-profit clinics which provide family planning services, documentation of services rendered and the establishment of policy and procedures in conformity with DMA's policy.

DPH agrees to monitor and evaluate the scope, quality, and utilization of family planning services and to provide clinic utilization reports to DMA. These reports must be sent to the Division Director, Program Management.

DPH agrees to submit a monthly computer tape to the DMA, Systems Management Division, which shall contain at a minimum the name and Medicaid number of clients receiving pregnancy test or other family planning services.

DMA agrees to provide reimbursement to the DPH for Medicaid covered services rendered to eligible recipients.

DPH, DFCS and DMA agree to work jointly in the development of policies and procedures for Family Planning services.

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Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Division of Family and Children Services (DFCS)

DFCS agrees that county DFCS offices will notify, verbally and in writing, all eligible clients under 21 years (at the point of application and each reapplication) of the availability and advantage of the EPSDT Program using the EPSDT pamphlet or other resources provided by DMA.

DFCS agrees that county DFCS offices will offer newly eligible clients screening and support services and will document acceptance or declination of the program. Dates of informing, acceptance or declination of the program will be documented by DFCS on Form 256. DFCS agrees to send the Case Summary Form and final case summary to DPH.

DFCS agrees to appoint a state eligibility representative who will serve on an EPSDT Interdivisional Committee, accompany Program Management staff on the quarterly EPSDT program overviews and make arrangements for Program Management staff to visit county DFCS offices.

Division of Public Health (DPH)

DPH agrees that case managers will contact all individuals listed on the DMA EPSDT newly eligible report, including SSI recipients, and all newly eligible EPSDT individuals on the first page of the final case summary form PARIS (DFCS Computer System).

DPH agrees that county DPH offices will assist eligible clients in locating participating Medicaid screening, diagnostic and treatment providers and offer support services assistance with scheduling appointments and transportation when requested for screening, diagnosis and treatment.

DPH agrees to develop and use in all counties a DMA-approved referral protocol.

DPH agrees that each county office will recall all eligible children including SSI children due rescreening using as their primary tool the EPSDT Due List provided monthly by DMA. DPH agrees to document the dates of recall and recall responses.

DPH agrees that case managers will contact recipients overdue for rescreening as listed on the overdue list.

DPH agrees that each county office will provide local Medicaid screening providers with information on the current screening status of children.

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DPH agrees that each county office will document and provide to Program Management information on the local provision of EPSDT informing, tracking, and follow-up on all eligible children.

DPH agrees to provide follow-up for screening, diagnosis and treatment within 120 days of receiving notification of eligible clients and acceptance of EPSDT services by client.

DPH agrees to assign full-time nurses to perform program reviews and evaluate the provision of EPSDT screening services in county health departments and provide reports to DMA. The reports will describe problems identified at the time of the program review visit and will outline a plan of corrective action and follow-up on the appropriateness of the corrective action, subject to DMA review and approval.

DPH agrees to provide training for DPH nurses who perform EPSDT screenings.

DPH agrees to appoint a state representative(s) who will serve on a EPSDT Interdivisional Committee, accompany Program Management staff to perform quarterly county EPSDT program overviews, or make arrangements for Program Management staff to visit county health departments.

DPH State Office agrees to set minimal standards and protocols for each component of the EPSDT examination or screening services, and to maintain written evidence of such standards.

DPH agrees that county case managers will inform EPSDT eligibles who are eligible for Title V services of the services available to them and will refer them to Title V grantees, if desired.

DMA will provide state DPH office with reports generated from data on the DMA-267.

DMA will provide state and county DPH offices with the following:

- EPSDT manuals and revisions
- EPSDT pamphlets
- EPSDT screen/claim forms
- Lists of new EPSDT individuals
- Quarterly lists of Medicaid and screening providers
- Lists of recipients due for screening
- Monthly lists of recipients 120 days late for rescreening

DMA agrees to reimburse DPH for screening services on a claim-for-claim basis at the reimbursement rate in effect on the date of screening.

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DMA agrees to provide the state DPH with the following materials related to the provision of EPSDT services by the health departments:

A quarterly screening report giving the number of individuals by age sequence receiving services, (subject to availability).

A quarterly report of child health status giving the numbers of children screened by age sequence and county and the type of abnormality referred, (subject to availability).

Statewide list of the numbers of Medicaid enrolled recipients by county twice a year.

A monthly claims processing activity report giving the number and reasons for claims being rejected, in-process or pending.

Provider ranking list twice a year.

Subject to Federal Regulation, DMA agrees to provide matching federal funds at 75% Federal for nursing positions to perform program reviews.

DFCS, DPH and DMA agree to hold interdivisional meetings at least quarterly.

DPH and DMA agree to conduct EPSDT program reviews in counties and to do so jointly with state representatives identified by the respective Division.

DFCS, DPH and DMA agree to work jointly to develop policies and procedures for the EPSDT Program.

Community Care Services Program (CCSP)

DFCS agrees to determine eligibility for potential Medical Assistance Only (MAO) clients appropriate for CCSP, to determine the amount of MAO client cost share liability, and to transmit this information to the CCSP case manager.

In conjunction with DMA, Division of Program management, Office of Aging and DFCS will develop and coordinate an appropriate vendor authorization payment system.

DFCS agrees to provide training for MAO Specialists.

DPH agrees to provide assessment teams comprised of a registered nurse and social worker. The attending Physician on the assessment team shall provide input verbally or through the provision of written medical data.

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DPH agrees to reassess clients as determined through standards and procedures established in conjunction with the Office of Aging and DMA, Division of Program Management, to determine the appropriateness of community care and the level of services needed if the client remains in the community.

DPH agrees to maintain and distribute the Program Policies and Procedures Manual for assessment teams. Any revision to these manuals must be submitted to OA and DMA, Division of Program Management, for review and approval.

The Office of Aging (OA) agrees to visit each service provider facility, where necessary, to assess physical conditions and compliance with established standards.

The OA agrees to provide technical assistance, training seminars and training packages for providers as determined necessary.

The OA agrees to arrange for the limits of services and containment of costs through the case management function. The case management function will be carried out through contracts with lead agencies.

The OA agrees to develop and update the Program Policies and Procedures Manuals for home and community-based waiver services provided under the Community Care Services Program. DMA will distribute these manuals.

The OA, in conjunction with DMA, agrees to coordinate a prior approval and prepayment review system to authorize services above the monthly limit but not to exceed the annual limit. This includes form changes, policies, procedures, system edits, etc.

The OA, in cooperation with DPH, agrees to provide to Program Management information needed to complete federal reports for 2176 waived services, i.e., HCFA 371 & 372.

The OA agrees to assist Program Management with the provision of information for all federal and state program assessments.

The OA agrees to submit to Program Management a monthly report reflecting program statistics regarding service utilization.

The OA agrees to provide Program Management with copies of the Client Assessment Instrument (CAI) and the Provider Notification Form (PNF) when either form changes.

The OA, in conjunction with DMA, agrees to establish standards and requirements for provider participation.

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DMA Program Management agrees to maintain, through DMA's Fiscal Agent, an automated case management client file.

DMA Administration agrees to prepare and submit to the OA a quarterly statement of expenditures by recipient, service provider and major service type.

Program Management agrees to provide to OA a monthly list of enrolled home and community-based service providers.

Program Management agrees to conduct utilization reviews for Community Care Services Program recipients and to provide written reports on UR findings.

DMA agrees to establish reasonable reimbursement rates for the provision of Community Care Services and to provide OA with up-to-date reimbursement rates for all enrolled and approved CSP providers.

Program Management agrees to work jointly with the OA on the development of policies and procedures for the Community Care Services Program. OA will involve DPH as appropriate.

Program Management agrees to notify OA in writing of any changes in related policy and regulation requirements needing incorporation into policy manuals. OA will notify DPH of changes as appropriate.

Community Mental Health and Mental Retardation Area Programs

Division of Mental Health and Mental Retardation (DMH/MR) agrees to conduct certification and re-certification reviews for mental health/mental retardation and substance abuse (MH/MR/SA) services rendered by Area Programs. Upon completion of each on-site review, DMH/MR will provide DMA with a summary of Area Program compliance with Federal regulations and DHR/DMA policy. The summary shall identify areas of non-compliance. A subsequent summary shall be forwarded to DMA on a quarterly basis which documents action taken to correct previously identified areas of non-compliance, and the certification status of the Area Programs review.

DMH/MR agrees to continue a utilization review program. Reports and analyses of these data shall be forwarded to DMA.

DMH/MR agrees to provide initial and on-going training for the staff who conduct the certification reviews for outpatient MH/MR/SA services and for staff who monitor and supervise the utilization review program.

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DMH/MR agrees to coordinate and supervise the implementation of provisions contained in DMA's Policies and Procedures for Outpatient MH/MR/SA Services and the DMH/MR's Policy Memorandum 40-01 and Quality Assurance Standards Manual Document, and DMH/MR's minimum requirements for area MH/MR Programs.

DMH/MR agrees to provide sufficient professional staff in the Office of Quality Assurance.

DMH/MR agrees to assure that all providers participating in the Community MH/MR/SA services program will prepare cost reports annually.

MH/MR agrees to appoint state office representatives to serve on an interdivisional committee.

DMH/MR agrees to work jointly with DMA in the development of policies and procedures for community MH/MR/SA services.

DMA agrees to reimburse area programs at rates approved by the Board of Medical Assistance.

Program Management agrees to provide area programs with manuals and manual revisions in a timely fashion.

Program Management agrees to work jointly with DMH/MR in the development of policies and procedures for community MH/MR/SA services.

Program Management agrees to hold interdivisional committee meetings with state office representatives of MH/MR.

Long-Term Care Services

DMH/MR agrees to be responsible for developing long-term care plan for ICF-MR residential services; monitoring the facilities for federal and state standards compliance; developing and providing in-service training and staff development for current ICF-MR facilities and facilities that wish to join the program; coordinating DMH/MR activities with the Office of Regulatory Services; and for obtaining statistics from the Georgia Medical Care Foundation regarding MH/MR recipients in long-term care facilities.

DMA, Division of Program Management, agrees to reimburse long-term care facilities for services provided MH/MR recipients according to rates approved by the Board of Medical Assistance.

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Rehabilitation Services

DHR, Division of Rehabilitation Services (DRS) agrees to provide Vocational Rehabilitation applicants eligible for Medical Assistance with notification of services provided under the Medical Assistance Program, and to refer Vocational Rehabilitation applicants under twenty-one (21) years of age to the EPSDT Program.

DMA, Program Management, agrees to provide DRS with literature which explains the EPSDT Program and the advantages of participation in it for distribution to vocational rehabilitation applicants under 21 years of age.

DRS and DMA agrees to furnish, on request, information concerning prevailing rates of payment for services.

Reimbursement

DHR and DMA agree that this is a cost reimbursement contract. DHR agrees to provide the state portion of matching funds necessary to receive Federal Financial Participation (FFP). DHR agrees that reimbursable costs will be determined in accordance with applicable provisions of 45 CFR Part 74, "Administration of Grants" and the approved DHR Cost Allocation Plan filed pursuant to such regulations. The reimbursable cost is for administrative and support services required under this Contract.

DHR agrees that the applicable provisions of 45 CFR Part 74 shall govern the administration of funds under this Contract and that DHR will observe and adhere to such requirements as detailed in Part 74, Subparts A, B, C, D, F, G, H, O, P and Q.

DHR agrees to submit financial statements detailing the costs incurred by DHR in carrying out the administrative provisions of this Contract. Such financial statements shall be submitted within sixty (60) days after the end of each calendar quarter and shall indicate the particular service by the type and applicable FFP rate. DHR will ensure that charges for Skilled Professional Medical Personnel (SPMP) included in financial statements will be in accordance with federal regulations regarding FFP for SPMP activities.

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DMA agrees to pay DHR the applicable FFP percentage of each service, with the exception of services provided under the Community Care Services Program, covered by this Contract as provided in the State Medicaid Plan and as detailed on the financial statement described in the previous paragraph.

DMA agrees to submit financial statements to DHR detailing the payments made to providers for services rendered under the Community Care Services Program. Such financial statements shall be submitted within sixty (60) days after the end of each calendar quarter and shall be in a mutually agreed upon format.

DHR agrees to pay DMA the non-federal share of costs as detailed on the financial statement described in the previous paragraph. DHR agrees to notify DMA of any payments included on this financial statement for which services are not authorized. Unauthorized payments will be credited to DHR promptly upon notification. DMA may recoup unauthorized payments from providers.

Any disallowance of FFP by the Health Care Finance Administration is the ultimate responsibility of DMA; however, DHR is responsible for all disallowances resulting from failure to comply with rules, regulations, policies and procedures, etc., relative to the terms of this administrative agreement. DMA will notify DHR promptly of any audits, financial reviews, etc., relative to DHR responsibilities under this agreement. DMA will provide draft findings and recommendations to DHR with adequate time for input before DMA's response, to assure both agencies' concerns and comments are addressed. DHR will respond promptly when notified by DMA. Financial responsibility for any repayments, sanctions, etc., will be determined on a case by case basis, depending on the circumstances and state budgetary requirements and restrictions.

Disallowance by the Health Care Finance Administration relative to areas where DHR is functioning as a service provider will be handled by DMA in the same manner as that of any other Medicaid service provider.

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